THE 2001 SCHERING LECTURE

Listening with more than your stethoscope: Feeling with more than your fingertips: Advanced practice nursing in oncology

By Pamela West

Stories, stories...short stories, long stories, small stories, tall stories, bedtime stories, Bible stories, true stories, make-believe (fairy) stories, ghost stories...Everyone has a story. You have a story and I have a story. Our lives are rich with stories and it is because of stories that we are who we are, what we are, where we are, and why we are. Stories help to shape our lives and shape our individual selves. Stories put into words what painters put into their art, and what musicians put into their compositions and music. The theme for CANO this year is "The art of communication: Discovery through sharing of stories" and today I want to share a few stories about cancer care and, hopefully, give you some insight into part of the evolution of cancer nursing in Canada, as well as a little of the history of acute care nurse practitioners, and a little about me and my story.

Stories

Why do we tell stories? I think the most important reason to share stories is to help pass on traditions and tales that have significance or are perceived to have importance in our lives; to communicate, to express our values and beliefs and to share them with others. Nursing is a passion for many of us - our *raison d'être*. Imagine if our patients were alone, without a family or friend, and were unable to tell us their story. We would be looking after a body in a bed. Yes, we would be able to do wonderful care of the physical shell, but we may not be able to touch the soul and spirit of that person.

Oncology embodies 'connecting.' How did we get to 2001 and when did we become an entity that enables us to proudly call ourselves **oncology nurses**? We need to look backwards in order to look ahead. What are some of the roots of oncology nursing? What was invented in each of the past five decades that is now taken for granted, but which may have influenced our development? Does a nurse graduating today appreciate the road that has been forged ahead of her or him?

I was born in the 1940s and, thus, I have lived through an entire five decades and am now teetering on the edge of my sixth. Along with all of you, I am entering not only a new decade, but a new century and a new millennium. My memories are precious to me. And as I share them, some of you will walk down this same path with me and others of you are invited to wander along. Jean Vanier (cited in Howat, 2001) said, "The greatest desire of every human heart is to find meaning to our lives and to the universe." Shall we see if he was right?

Pamela West

As a prologue to my story, I want everyone to remember that the 1950s followed WWII during which women had, because of necessity, left their homes and joined the workforce, a novel, scary, yet exciting experience. Before WWII, it was rare and unusual for women to work; the only jobs available were secretarial, teaching, and nursing. Yes, the occasional woman went into law or medicine, but it was not looked upon with respect or admiration. It was seen as an act of rebellion or perhaps even viewed as strange that a woman would do such a thing in a man's world. When the "boys" came back from the war, women returned to their homes to be mothers, wives, and homemakers so that the employment doors could be reopened for returning soldiers. By the late 1950s, women had begun to become restless and, as they had been so successful in the employment arena in the previous decade, they re-entered the workforce in numbers greater than ever before.

The fifties

The world was rebuilding after World War II – there was lots of love and lots of living to be done. Babies (now called boomers) were born at a great rate (although I think it still took the required nine months). As for cancer care, surgery was the mainstay of treatment. However, in the fifties, "it was noted that despite technical sophistication... mortality rates associated with certain cancer sites were not improving. Many tumours thought to be local processes were discovered to be systemic diseases with metastatic lesions" (Otto, 2001, p.585). Thus, surgery began to be augmented with radiation and systemic therapy. Radiation, although a treatment modality since 1898 (Otto), was radically altered in this decade by the development of radioactive cobalt. As well, by the end of the decade, linear accelerators began to provide "treatment rays with deeper penetration and less scatter to normal tissues" (Otto, p.606). Chemotherapy really got its start in this decade and soon became another very important adjunct to treatment. DES and methotrexate came to the fore and were added to the first agent, nitrogen mustard, which had been initially used in 1942.

Antibiotics were also just beginning to be given for infections and sepsis. The sulphonamides were starting to appear. Penicillin in particular was the panacea for everything. As a young girl with scarlet fever, I was given daily injections of penicillin while in my quarantined bedroom. Prednisone was also a new drug and my grandmother was part of a clinical trial in 1955, although I do not think it was called that in those days. Grandmother was a bad rheumatoid and, as a last-ditch effort in hope of giving her some reprieve from her pain and degenerating joints, she was asked to try this new drug. Wonder of wonders, the degeneration, the inflammation, and even the pain in her joints were lessened by this miracle drug. She died in 1956, but I am sure that her data contributed to the body of knowledge and helped to put prednisone on the map as a viable and worthwhile drug (and part of the plethora of drugs we use with cancer patients today).

Nurses had a three-year program primarily taught by doctors. These programs were affiliated with hospitals and schools of nursing. There was no charge for school and nursing students were supplied with their room, board, uniforms, and a small allowance which increased based on experience from \$8 a month after probation to \$12 a month by the end of training. University education for nurses was still a rare entity in the fifties and, although there were some baccalaureate programs, they were few in number and only very rich attendees registered.

What revolutionized the fifties? What was nursing 'like' then? Well, nursing very much involved caring for the physical person and

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providing comfort. Care and comfort meant fastidious, meticulous neatness where sheets were tucked in tightly and patients were scrubbed with such things as dettol and phiso-hex to ensure their cleanliness. Cleanliness, after all, was next to godliness. All hospitals smelled like ether or chloroform. Inspection by a matron was mandatory and your merit and value as a nurse was based on your ability to follow rules and keep everything scrubbed and tidy. Nurses were the servants of the hospital and always followed orders. The medical model ruled. No credit was given for thinking on your own or questioning anyone or anything. Crisp, white (albeit sterile) uniforms were the order of the day and the length had to be mid-calf. Starch played an important part in dressing. Not only was the bib that you wore starched, but so were the uniform collar, cuffs, and, of course, the cap. Underneath the exterior uniform were proper undergarments and, of course, mandatory white stockings held up by garter belts or girdles. One was not allowed to wear make-up or jewelry except for a watch with a sweep hand. Hair had to be three inches above the collar. Nails were clean, short, and functional without even clear nail polish as it was a site for the accumulation of bacteria. These were 'the good old days.'

And, you are right. There was no oncology nursing. What was oncology anyway? Cancer was a word that was whispered and alluded to in a hushed voice, often referred to as the big "C." The words that came out of the closet in the 1950s were alcohol and alcoholism. And a perfect fifties nurse never drank....

On a more practical vein, televisions had just entered the world. In our home, we did not have a TV until 1961 but, occasionally, I watched a special program at a friend's home. We did not have dishwashers, air conditioners, barbecues, or automatic anything. There were wringer washers, fans, ice boxes (a few refrigerators), and wood and gas stoves. Bread, milk, and often fruit and vegetables were delivered to the door and sometimes in horse-drawn wagons. The dry cleaner came weekly, as did the egg man and the Fuller brush man. Very few women drove a car! Many families in Canada did not even own a car. Everyone went to church and women wore hats and gloves whenever they went out. There were no rollers for your hair, only bobby pins and rags. Life was family-oriented and people celebrated their freedom and new opportunities for work and travel. One could fly via turbo-prop planes to various points in Canada, and the occasional traveller began to brave trans-Atlantic flights, although people still preferred the steam ship to go to England or Europe. It was the dawn of Elvis Presley and rock 'n roll, and we all bought '45s' to play on our record players.

The sixties

All this changed in the sixties. The sixties was the era in which I would wager a few of us in this room 'trained.' We still went to schools of nursing attached to hospitals and we hardly paid a fee to study because it was an expectation that you would do your shifts and your weekends and contribute to patient care as a member of the team. For the most part, nursing programs were three years in length. The occasional school of nursing tried a two-and-a-half year program and a few very brave schools developed a curriculum that was only two years in length, but included summers. Doctors were less visible in nurses' education. Knowledge was ballooning and televisions made learning and the sharing of information as easy as flipping a switch. Nurses who were university graduates were 'called' to teach and shape the nurses of tomorrow.

My dad actually paid \$100 a semester for me to go to the Hamilton and District School of Nursing. However, room and board, my uniforms, books, etc. were all included. I remember getting \$10 a month for an allowance, and with that I did everything; buy my toiletries, polish for my duty boots, red licorice (still my favourite treat), and cigarettes. Nearly everyone smoked in those days and nurses were among the largest offenders!

There was still a tremendous number of rules to be followed. For example, one's uniform had to be four inches below the knee, and your hair had to be short, or up in a bun and above the collar. Some

schools of nursing still had starched pinafores and bibs, but they were gradually fading out of the picture. Everything remained rule-regulated. I dropped a tray of glass thermometers in training and had to pay \$3.68. And that was a great deal of money in those days! Gail Donner, a nursing leader in Canada and recently retired dean of the Faculty of Nursing at the University of Toronto, recalls hospitals in the sixties as being "rigid" and full of "hierarchical policies" that compromised the care she felt patients needed and deserved. Bed linen was changed once a day, but in order to make one of her dying cancer patients who had perspiration-soaked sheets comfortable, she had to "feel like a thief" and grab and stash extra linen when the head nurse's back was turned! (Rachlis & Kushner, 1989, p.255).

So, what specifically revolutionized the sixties? Medicare was introduced in Saskatchewan in 1964, and the concept of accessible health care for all, regardless of income, age, or need, did much to change history. No longer was health and illness care a luxury. Thus, there was a much greater demand for care and an amazing increase in the number of people coming to hospitals for admission and treatment. From a very practical aspect, pantyhose was one of the best inventions of the decade!

Pharmaceuticals exploded! Antibiotics were gradually becoming more specific to a variety of different pathogens and, out of the blue, people began to have allergies! Just as 'alcoholism' came out of the closet in the fifties, 'death and dying' were buzzwords in the sixties. The work of such leaders as Dr. Cecily Saunders and the birth of the modern-day hospice movement helped to change the way nurses and others on the health care team viewed the concept of death. This definitely impacted on cancer patient care.

As for oncology, drugs such as the vinca alkaloids and anthracyclines were developed, and this changed the face of some of the most dreaded cancers, actually making a difference in overall survival. By the end of the decade, cisplatin was also in vogue. Systemic treatment became an increasingly popular treatment option and research into drugs and drug therapies became a livelihood for some scientists. Hematologists first gave chemotherapy. This physician group was one of the first subspecialties of internal medicine and, in 1966, wrote qualifying exams through the Royal College of Physicians and Surgeons of Canada (RCPS[C]).

In the real world, jet planes were being flown everywhere. Door-to-door delivery of the necessities of life was beginning to be a luxury. With the evolution of strip malls, people wanted more choice and had more money to spend. Things were changing fast! Music was fast! Cars were fast! Women were fast! And so were nurses! Music was strongly influenced by groups such as the Beatles and the Rolling Stones. Everyone owned a transistor radio.

The seventies

The seventies was an incredible decade. I worked throughout the entire 10 years as an RN and I remember many of the exciting changes that took place. When the decade began, we worked 10 shifts in a row: 10 days, 10 evenings, and 10 nights with our days off in between. In 1970, my gross salary was \$406/month and then went to \$411/month after three months' probation. With the establishment of unions in 1974, salaries increased substantially (I think I went from about \$7,000 to \$14,000), and by the end of the seventies, we worked no more than eight shifts in a row.

I worked in a Department of Veterans' Affairs (DVA) hospital in Winnipeg and, on nights, an orderly and I were responsible for the care of 56 men on "Wards P and Q." I might add that we cared for them very well and often got a few games of cribbage in during our shift! Mini-skirts became popular both in and out of the hospital community. As a registered nurse, I bought my own white uniforms and the shorter length the better! This was, of course, much to the chagrin of the older nurses, especially the nursing sisters who, although approaching retirement, were still very much present and always in charge. Of course, the ultimate authority was given to physicians, and nurses

stood up in the nurses' station whenever a doctor entered. Nurses were identified by their caps; there were many different styles with, and without, black bands. By the end of the decade, although one still wore white uniforms, pant suits were acceptable and wash-n'-wear fabrics made the wearing of uniforms much easier (not to forget the improvement in washing machines and spin dryers!). Plastic cards, especially VISA (originally called Chargex), became an important and convenient way to manage one's finances!

Moreover, nurses in the seventies were efficient. We were so efficient that we could work anywhere and everywhere, and often did. If you were 'floating,' you could relieve in the ICU and manage a Bird respirator; go to the nursery and feed and bathe a newborn; prep a surgical patient by doing their shave or by giving them their prescribed enema. Specialization and sub-specialization were just beginning. The body of knowledge was burgeoning and many nursing programs returned to three years, especially after 1974 when schools of nursing left hospitals and were subsumed by community colleges. More doors were being opened at university for nurses. Universities began to develop Master's education along with their undergraduate nursing programs.

In cancer care, some internal medicine specialists began to focus on cancer. Gradually, floors or units managed by these physicians became dedicated to one specific disease entity. As physicians became more specialized, nurses gradually assumed their expertise, more by circumstance than by choice. If you worked on a medical floor run by six internists all of whom cared for cancer patients, by 'osmosis' you too became knowledgeable. In fact, it was in the seventies that the word 'cancer' actually came out of the closet and began to be a safe and acceptable word one could state in an audible voice. Radiation oncology became a sub-specialty of internal medicine and the first national exam was written in 1976. CHOP became the gold standard for non-Hodgkin's Lymphoma (and still is today). New drugs in the seventies included Tamoxifen and VP-16 or etoposide.

VCRs were invented in the seventies. The Eagles and Harry Chapin were popular. Computers were something that one read about! They were changing businesses and rapidly replacing personnel. However, health care was not to see the arrival of computers until the eighties when most large hospitals adapted everything to a local area network (LAN).

The eighties

The eighties were again exciting years and, for me, probably the decade of the most change. 'Post-its' were invented and so was velcro. CDs came into being and in the music world, 'heavy metal' was in vogue; vinyl records became collectors' items. The word that dominated our culture, and was very much in evidence both in and out of health care, was AIDS. And, of course, we who work in oncology know that this disease has had, and sadly still does have, a relationship with cancer.

I went back to school to do a post-RN baccalaureate degree. I also decided to work forever in 'oncology.' So to affirm this commitment, and while at university, I slanted as many papers and presentations as possible in cancer's direction and enjoyed three clinical placements in cancer centres. In 1985, the Royal College of Physicians and Surgeons (Canada) recognized medical oncology as a sub-specialty. It is hard to believe that, unlike surgical and radiation oncology, medical oncology has only been around for 16 years! The Canada Health Act in 1984 impacted our system, too. It was an attempt for nurses nationally to rally together and advocate that 'medical insurance' be changed to 'health insurance' so that all health care professionals provide insured services. As well, the role of the expanded-duty nurse was recognized and nurses became a visible force in the advancement of health care for all. Nurses were perceived as a social and political movement and, despite the fact that some of what the nurses lobbied for did not pass legislation, author Mary Jane Growe says that the time around this period "was their [nurses'] finest hour" (1991, p.228). Extra billing

was eliminated and poorer Canadians had better access to physicians. One day, about that same year, I remember calling a physician (younger than I and just beginning his new internal medicine practice) "Sir." He invited me to call him by his first name, and I almost fainted!

The year 1984 was also important for cancer nurses because a small group met in Hamilton to try to form a national group that would move cancer care nursing forward, and to support one another in various aspects of clinical care, education, and research. The Canadian Association for Nurses in Oncology (CANO) came together in 1985 in Edmonton when 150 nurses unanimously voted to form a national organization. In 1988, the first national oncology conference was held in Vancouver, and I was privileged to present a paper there.

The value of education became paramount. It was recognized that new technology brought new developments, and the sciences of medicine (and subsequently nursing) were becoming so enormous that one had to make choices about what one wanted to do and where one needed to focus one's area of study. To be considered an expert and to give patients the specialized care they deserved, a dedicated and somewhat narrow field of interest needed to be determined.

Expectations for ongoing or lifelong learning appeared. The first PhD in nursing was established in 1987 at McGill University. Provincial bodies began to demand baccalaureate preparation as the minimum entry to practice and, as of 2001, five of 10 provinces have mandated this tenet. To sit around a table with an interdisciplinary health care team whose members are minimally prepared at the bachelor's level puts diploma-prepared nurses on an uneven playing field. Nurses are most capable of a leadership role in patient management, but without the recommended education, they may be viewed as second-class citizens instead of assuming the key role that is justly theirs.

It also became harder to recognize nurses in the eighties. Everyone looked the same. Pantsuits, scrubs, coloured uniforms, originally pastels, soon began to be worn by a hatless group. Are you an RN? Are you an LPN or RNA? Are you a health care aide? Better wear your pin and better conduct yourself appropriately or no one will know. Better still, identify yourself to your patients every day. At least they should have the privilege of knowing who you are and what you can, or cannot, do for them!

Biologicals such as interferon were becoming evident. Bone marrow transplant was beginning and early results were discouraging. Some cancers, however, were being cured and consumers were beginning to ask more questions. We were beginning to listen with more than a stethoscope. As Henri Nouwen, the great Christian writer, said: "Without listening, speaking no longer heals and the distance without closeness cannot cure." We were reaching out and touching our patients, competing with a technology that took us further away. We were beginning to demonstrate what I call human-to-human connectedness.

The nineties

Patient participation and question-asking became more acceptable and even trendy in the nineties. Computers were now a part of the workplace and most Canadians had their own PC at home. Some people even had laptops so they could work 24 hours a day instead of the legislated eight- or 12-hour workdays. Consumerism was a movement in the nineties and it forced nurses yet again to become more informed and knowledgeable. In fact, nurses had to try to stay at least one step ahead of patients who read about their illness on the internet and often knew some aspects of their disease and its treatment more intimately than even medical oncologists knew! National certification was born in 1992 and in September 1997 oncology nurses wrote the first national exam to receive the CON(C). CANO was a driving force in the development of the content of this four-hour test. Uniforms (if you can call them that) radically changed. Now even more colourful - sometimes even wild - it was difficult to tell a nurse from a visitor, let alone another health care professional. However,

there were still some redeeming features about the '90s nurse, although there were radical differences from the previous four decades. The nurse still knew everything there was to know about vital signs, although now a mouse replaced the mandatory stethoscope, and everything from tympanic temperatures to blood pressures and oximeters were automated! Computer technology in the nineties became a standard of care; documenting on-line, ordering on-line, and, most recently, looking at scans and tests on-line. The words that came out of the closet along with the individuals were 'homosexual, lesbian, and transvestite.' Gay did not necessarily mean happy.

I returned to university in 1990 to do a Master of Science degree and once again I was able to focus most of my course work, clinical experience, and thesis on oncology. At the end of the decade, I prepared to go back to school to study to become an acute care nurse practitioner (ACNP), thus framing the decade with the privilege of higher learning.

The nineties saw medications related to cancer alter practice more than any other previous decade. The introduction of such drugs as ondansetron (zofran), the taxanes, and newer hormone manipulations enabled a better quality of care for patients during chemotherapy and afterwards. Clinical trials radically changed as well. In the mid-nineties, the NCIC recommended that a quality of life instrument be a required component of research. It was not enough that willing patients were recruited and studied. 'Overall survival' (OS) was no longer the only acceptable endpoint in research. Now we needed to know if the drug/treatment/protocol made a difference in the lived experiences of our patients, and if they made things better. We were moving beyond the doing of things 'on' patients, 'to' patients, and 'for' patients; we were moving to doing things 'with' patients and, even better, we were doing what patients wanted us to do. What a wonderful role reversal! And speaking of role and perhaps even a bit of reversal, let us look at the acute care nurse practitioner and how this may fit in to the evolution of oncology nursing in Canada. Another chapter opens up.

Acute care nurse practitioners

Just as we reviewed the history of oncology nursing, let us briefly look at the history of nurse practitioners. Where did we come from and just who are we, anyway? Biomedical knowledge and technology had exploded in the past 20 years with the dawn of, in part, computer technology. Historically, physicians had gradually handed over some of their skill set to nurses. When we began nursing, we did purely custodial care. Gradually we were given the privilege and knowledge of taking 'vital signs.' Soon we learned how to give injections and then to insert intravenous and central lines. In oncology, particularly medical oncology, only physicians initially gave chemotherapy, and now they rarely, if ever, do so. As the scope of medical care increased, so

increased the scope of nursing care. Like a fountain of knowledge, the wisdom of physicians gushed over the sides, bubbled up, and spilled over to those ready to lap it up. And here is where you find ACNPs and their 'new' role, considered by some to be a 'physician extender.'

The actual movement of these advanced practice nurses began in the United States in the 1960s, and was initially a short-term answer to decreased physician enrolment and resident replacement. In the mid-70s, Canada stole one specific program for neonatal intensive care practitioners and established a curriculum at McMaster. A few other programs came to light, though, sadly, had a very short life. By 1982, because of a great deal of opposition and primarily physician resistance (were we perceived as a threat?), the NP programs soon died. However, whether it was stubbornness/persistence or a never-say-die attitude, or perhaps based on need (maybe a combination of everything), the '90s saw the rebirth of the NP movement. A clear definition of the role and its scope, coupled with a strong emphasis on collaborative practice, has gone a long way to help its resurgence and newly-found acceptance. One definition of the role that I particularly like is as follows:

An NP is a registered nurse with appropriate accreditation who practises within a professional role. He/she has autonomy within the work setting, and has the freedom to make decisions consistent with his/her scope for practice, and the freedom to act on those decisions. (Roberts-Davis, Nolan, Read, & Gilbert, 1998, p.38)

In Ontario, and I believe that this is true for most provinces in Canada, there are two distinct roles: primary health care nurse practitioners (PHCNPs or RN-EC [extended class]) and acute care nurse practitioners. Nurse practitioners are governed, promoted, and cared for by provincial bodies. Table One shows the qualifications required for the two roles and their differences/similarities. Presently there are about 500 nurse practitioners in Ontario; 300 are primary care and 200 acute care.

Both roles are guided by medical directives. ACNPs' directives reflect their individualized area of expertise, while medical directives for RN-ECs are a provincially-set package of 'do's and don'ts' determined by legislation. A directive may be defined as "a prescription for a procedure, treatment or intervention that may be performed for a range of clients who meet certain conditions" (CNO, 1995).

Poised on the edge of this new decade, century, yes, even millennium, the time may be ripe for this role. With an emphasis on cost containment and efficient use of resources, good management of technology, and differential decision-making, the role is becoming more and more popular and better accepted, not only in university-affiliated hospitals, but now, too, in community hospitals. The practitioner, with graduate education and experience-based learning, can make a difference in the provision of evidence-based practice framed by a strong theoretical and research platform and a passion for the role (Porter-O'Grady, 1997). A typical role is a nice blend of primarily clinical practice peppered with education, research, a little administration, and some academia. Physicians hand-in-hand with practitioners are "moving from the role of proprietor to partner" (Porter-O'Grady, p.4) which is, to say the least, an incredible shift in their (the physicians') values and beliefs, and necessitates incredible change in attitude. Historically, physicians have been "independent, entrepreneurial, non-allied and for the most part involved in relatively freestanding practice arrangements" (Porter-O'Grady, p.4). Porter-O'Grady does not view the change as peaceful, quiet, or understated. Like the nurse of today, physicians are beginning to adapt to something that we have known all along: patient-focused care. We are all being restricted by the dollar, and if we can decrease length of stay (LOS) and achieve good outcomes within a defined period of time by working together, it will be a win-win situation for everyone; first and foremost for the patient. For the first time in history, the health care system must interface tightly with the community, i.e., the people that it serves. We can no longer be compartmentalized and work in silos, let alone ivory towers. No one discipline can define itself out of context of its relationship to another discipline. Its contribution, its

Table One: Nuances of the ACNP and the PHCNP (RN-EC)

ACNP	PHCNP (RN-EC)
• specialist	• generalist
• sees a certain disease state and usually adult OR child focus	• sees all ages and all stages
• focus is pathology	• focus is health promotion and disease prevention
• legislation pending, so works with medical directives	• recognized by a provincial government and able to put RN(EC) after one's name
• study usually one year post Master's degree	• study post at least a baccalaureate degree

work, and its relationship will be dependent on every other discipline's participation and contribution (Porter-O'Grady). We are a conglomerate of health care professionals who work together to achieve the great and glorious goal of excellence in patient care. At all times, patient needs are the priority (Ackerman, Norsen, Martin, Wiedrich, & Kitzman, 1996) and the nurse practitioner is poised to make sure that these needs are met and not missed. Evaluation of the role should be based on these two points (if nothing else).

In my own practice, my role is fairly broad, definitely varied, and never dull! We have a 23-bed in-patient unit which is more or less dedicated to oncology patients at different stages of their illness. We may have patients with newly-diagnosed lymphoma, one or two patients with febrile neutropenia, several with recurrences at various stages, two or three receiving highly emetogenic, complicated chemo regimens, and a few who are in the end stages of their lives. In essence, there are enough patients with complex needs to keep me occupied and out of mischief! I do history and physical examinations, dictate my findings, and determine and prescribe a plan of care. I often feel a bit like a mechanic as I tune up the person and try to make their physical and spiritual selves in as good a shape as possible.

I work with three medical oncologists, all of whom rotate weekly on the in-patient unit. So for example, Dr. A is on the floor when Dr. B is managing the chemo clinic and Dr. C is focusing on the literature, clinical trials, catching up on his backlog of dictations, or perhaps attending a conference. The following week, Dr. B will be on the unit, Dr. C in the clinic, and Dr. A doing the 'odd jobs' and so on. What it means is that I have the privilege of providing continuity of care for patients and families from week to week with a different physician mentor. And, lucky me, I quite delight in these physicians' different and unique personalities and approaches to care. Each physician is brilliant in his own unique way, and each has his own special endearing characteristics. Because of their individuality, I get to smooth over the waters when one doctor says one thing on Friday and the following Monday the 'new unit doc' changes everything around to reflect his approach to care. One doctor likes my nursing approach; another wants me to be more of a physician and less a nurse; and the third doctor is quiet (and one never knows exactly where one stands). Are you beginning to see my challenges???

Nursing will never remain static; it has not throughout its history. It is instead a dynamic profession; ever-growing, ever-changing, and ever getting better, hopefully for both its participants and its recipients. In this new millennium, the quality of life sought by our patients and the quality assurance demanded by them as a minimum standard of care has changed to something called evidence-based practice. Why do we do what we do, and why is nothing done without reason and rationale? In part because of the constraints of our modern-day health care system, and in part because our patients have demanded it.

The DiCenso, Cullum, and Ciliska (1998) model for evidence-based practice really fits with what I see NPs doing, and being able to do well. In this model, clinical expertise, resources, research evidence, and patients' preferences are all interlinked in overlapping circles. A nice blend of all four aspects of the model helps keep everything running smoothly. If we continue to place greater emphasis on patient needs and wishes, do things with patients, and even 'let' patients make their own decisions, is this not a metamorphosis in philosophy and a complete paradox from what care was like in the fifties and sixties? Chinn (1991) says oppression is achieved through the control of knowledge, and that is why nurses have always been somewhat subservient in the male-dominated hierarchy of medicine. We no longer have to worry. Our patients are participating in this knowledge revolution, forcing everyone in health care to feel with more than their fingertips, and listen more than ever before. Health care professionals, patients, and families can discuss the patient's problem, and, ideally, the informed patient can make a decision that is right for him or her. Gone, or going, may be those hierarchical hospital policies that Gail Donner (Rachlis & Kushner, 1989) experienced in the sixties.

Constraints, both in finance and human resources, coupled with consumerism, force a different approach and philosophy to health care. I think I now know what health care reform means. It means, dare I suggest it, a movement from the medical model of yesterday to the nursing model of today. Finally, after all these years, I think we are headed in the right direction. Overall survival has been replaced or at least augmented by the quality of life measurements in all research. We do not deal with merely objective data and facts, but with subjective opinions and experience. It is a known fact that we no longer treat the x-ray, but rather the person who has had the test or scan. Yes, I believe that we are on the leading edge of yet another revolution in health care and this time nursing may actually win!

Why do I say this and what makes me so confident? Well, if one reviews what the medical model is like and contrasts it to the nursing model, in part this is what one sees (Watson, 1988): a movement from the mechanistic view of physicians to the humanistic view of nurses; a move from ordering the patient to do everything or have everything done to them, to negotiation with the patient and discussion of ideas with a capable and well-trained team of experts who want only to facilitate the best for the patient; and a move from reductionism to whole person care (see Table Two).

The advent of nurse practitioners does not change the underlying philosophy of nursing, but promotes it and, hopefully influences, albeit slowly, the practice of physicians. Several exemplars may help to illustrate my perspective and to demonstrate how patients increasingly drive decisions and health care professionals increasingly take a back seat.

Dr. C. was on the unit. A newly-married (eight months), 41-year-old bride wanted to go home for the May long weekend. She had newly-diagnosed, very advanced NSCLC which impinged on her esophagus and made swallowing almost impossible. Dr. C. made me feel terribly guilty because, although I had suggested a pass, the patient had said 'no' to a pass and only wanted a discharge. I finally agreed, although I agonized over the decision. Two hours after her discharge, I had to phone her drugstore for an antibiotic when the results of her most recent chest X-ray appeared in the computer and demonstrated new infiltrates. Had I done the wrong thing in letting her go? I later bumped into Dr. A (a doctor who is younger and definitely influenced by this new 'model' of care) who assured me by asking was 'quality of life' not a part of what we did, and did it not feel right to empower the patient? He reinforced the decision to let her do her own thing, even if it meant accepting the consequences of her own behaviour/decision, whatever that may be. For the next while, at least twice daily, I put her name in the computer, fully expecting to see her re-admitted. Ultimately, she died peacefully at home two weeks later and her husband returned to thank us for everything we did. She had made the choice to go home, and we had supported her or she would never have made it. She was in charge; in control - how wonderful - yet sometimes how scary that control thing can be!

Table Two: A changing view of health care

Medical model	Nursing model
• mechanistic	• humanistic
• objective data and facts	• subjective opinions and feelings
• reductionistic	• whole person care
• hard science	• soft science
• quantity of life	• quality of life
• ethics of science	• science of ethics
• dictatorial	• democratic
• directive	• participative

I like to think that kindness and thoughtful caring have existed throughout my life and most especially in my professional life. The following scenario attests to these attributes and the benefits of a concerted team effort. A 47-year-old woman with end-stage ovarian cancer lived in a summer resort area of Ontario about 150 miles north of our hospital. She wanted to die at home. Again there was a great deal of resistance, but ultimately the patient was the victor. On the way home in a rented private ambulance, she spoke with the paramedics who were transporting her and asked if she could have one more moment in the sun; to feel the breeze and smell the fresh air. The ambulance attendants agreed, but unbeknownst to the woman, decided to take her to her favourite lake (near her home). Here they not only opened the ambulance door, but transported her in her stretcher to the nearby dock. They rolled the gurney to the dock's end and then let her lie there on her own for several minutes, drinking in the sunshine, listening to the water lapping up against the dock, and breathing in the fresh, clean, northern air. A smile began to spread across her face. She was home. Having spent a few minutes on the dock, the drivers then drove her to the house and tucked her into her own bed, where three days later she died. How happy her health care team was because we had all helped to realize her dream!

Another patient who had obvious metastatic disease, but whose primary was of unknown origin, chose not to have any more tests done but to live with his cancer and whatever came to pass. His bone scan was terrible. He was riddled with his disease. However, why bother with CT scans, biopsies, etc. when he did not want any specific treatment such as chemotherapy? I worked hard to convince him and the nuclear medicine physician and his GP (who was a family friend) that he should take a shot of strontium, a radioactive isotope. All were in agreement; most importantly the patient. It worked out well! His pain was reduced substantially. In a matter of days and over the next four weeks, he was off almost all his medications, both opioids and co-analgesics. This demonstrated a blend of collaborative practice, risk-taking, and, fortunately for me, good luck! It was a moment of patient advocacy that could have failed!

But, it is not only health care professionals who practise patient-focused care. More and more, informed and wonderful families assume the burdens and benefits of care. I will never forget the daughter who sat up with her mum when she was dying. When she felt that her mum was cold, she jumped in under the covers with her and "spooned" and cuddled her, and ultimately fell asleep cradling mum in her arms. When the daughter awoke, her mum had died in her arms. How privileged she felt that she had been able to provide that security for her. Amazing death! Amazing patients and amazing families!

Have you noticed that I have not really dealt with the specifics of this new decade? We live it every day. I am not sure that I could shed a great deal of light on each of your individual workplaces. You will have to explore your own realities and test out some of what I have

been telling you to see if there is truth in it for you. As well, I am not sure what word will come out of the closet in this decade. Without sounding too hokey, I would like to think it might be love, as defined by a 20th century saint, Thomas Merton. He says, "Love means something much more than mere sentiment or token favours. Love means an interior and spiritual identification with one's brother and sister so that they are not regarded as 'objects' to which one does good" (fresco at King's College, London, Ontario, 2001).

Nursing by definition is in part nurturing. It is the care of human beings; people who should be viewed and treated as a unified whole, people who interact with their environment and those around them on many levels. Nurses continue to play a leading role in this care. Further, according to Picard (2000), "Nurses are still far and away the most trusted professionals in Canada." (p 4). Therefore, we need to stand as a collective and speak up, nay shout, in defense of and protection for our precious role. In the year 2000, there were 263,000 nurses in Canada. I am not sure how many were practising. I do know that some who have not nursed for a while are coming back to the profession, though sadly some are leaving. Perhaps if we tell our stories and support the movement or progress to a predominantly nursing model of care, even more nurses will return to the fold. I very much hope so. Thank you for sharing in my story. I would like to close by sharing with you a loose translation of an old Hebrew prayer that puts my sentiments into words much better than I could ever write or imagine:

The Journey of Life

For each of us life is like a journey.

Birth is the beginning of this journey, and death is not the end
but the destination.

It is a journey that takes us from youth to age, from
innocence to awareness,

from ignorance to knowledge, from foolishness to wisdom,
from weakness to strength, and often back again.

From offense to forgiveness, from loneliness to friendship,
from pain to compassion, from fear to faith,

from defeat to victory and from victory to defeat,
until, looking backward or ahead, we see that victory does not lie at
some high point along the way, but in having made the journey,
step by step.

Adapted from an old Hebrew prayer

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